

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2013	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 225 SS=D	<p>The following citations represent the findings of a partially-extended complaint investigation with the complaint numbers #70699 and #69671.</p> <p>A revised copy of deficiencies was electronically sent to the provider on 12/24/13.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>			F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 52 residents with 7 residents included in the sample. Of those, all 7 were reviewed for reporting of injuries of unknown origin to the state. Based on interview and record review of a closed record, the facility failed to immediately report an incident involving fractured ribs to the State survey and certification agency for 1 of 7 sampled residents. (#3)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #3's signed physician's orders sheet dated 11/4/13 revealed diagnoses including the following: type 2 diabetes without complications (when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), depressive disorder, and inflammatory disease of the prostate. <p>The electronic record face sheet revealed the resident admitted to the facility on 9/30/13.</p> <p>Review of the resident's Admission MDS</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>(Minimum Data Set) assessment dated 10/13/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 6 (severe cognitive impairment). It revealed the resident needed limited assist of 2 people for bed mobility, limited assist of 1 person for transfers, walking and locomotion. The resident had a fall in last month prior to admission, and in last 2-6 months prior to admission, but had not experienced falls since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) for Admission MDS revealed the resident needed limited to extensive assistance from staff for transfers and ambulation, and had moderate risk for falls. The resident used a walker with ambulation, needed to be reminded to get up slowly, and stand for a little bit before walking.</p> <p>Review of the undated Admission Care plan revealed, "At risk (for falls) score." It also revealed the resident needed assist of 1-2 staff for transfers, ambulated with 2 person assist, and needed assistance of 1 for turning and repositioning. It revealed, "Toileting q2hrs (every 2 hours) and PRN (as needed)." It also revealed the resident oriented x 2 (to person and place), disoriented, forgetful, and had dementia/Alzheimer's (progressive mental deterioration characterized by confusion and memory failure).</p> <p>Review of the comprehensive care plan revealed revealed a focus initiated on 11/1/13 indicating the the resident had an actual fall and unsteady gait and poor balance.</p> <p>A note on 11/1/2013 at 11:47 A.M. revealed the resident in the bathroom, and fell outside of</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>bathroom. The resident stated he/she was trying to walk without a walker. The record lacked any information on when staff last saw the resident, if the resident needed assistance to get to the bathroom, or supervision in the bathroom, if all other comfort needs were met, or if care plan interventions were followed or still effective in helping to prevent future falls.</p> <p>Review of a nurses note dated 11/2/2013 at 2:09 A.M. revealed the resident continued on fall follow up and complained of pain in the right lower rib area. Staff notified the physician and received an order for a rib X-ray.</p> <p>Review of a Preliminary Report from Radiology Services Corporation revealed 11/2/13 reason as pain after fall 11/1/13, Findings: Fracture 9th rib. No underlying pleural or parenchymal traumatic/post traumatic changes</p> <p>Review of the Aide Documentation Report for November 2013 revealed, "Toileting Program (restorative): Take to bathroom every 2 hours during waking hours." During an interview at 1:45 P.M. on 12/12/13, Consultant C reported the charting program and cueing information for staff was not initially set up for individual resident needs. When a resident admitted to the facility, questions/cues like taking to the bathroom every 2 hours were automatically turned on for all residents. Staff C reported the direction did not specify whether staff needed to stay with the resident, or directions not to leave the resident unattended.</p> <p>During an interview at 2:08 P.M. on 12/12/13, Administrative nursing staff B reported he/she did not have any evidence to show an investigation</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>had been completed to determine whether staff assisted the resident as the resident needed, and had nothing to show that staff did not leave the resident unattended on the toilet.</p> <p>During an interview at 4:43 P.M. on 12/16/13, Consultant C reported the resident received a fracture, but did not have any evidence the injury was reported to the state. Consultant C reported he/she did not know why staff did not call the incident in, but reported the fracture needed to be called into the state.</p> <p>Review of the facility's undated Abuse, Neglect, and Exploitation policy revealed, "It is the policy of this facility to as thoroughly as possible, investigate incidents affecting all aspects of resident care. The facility will take a proactive approach for identifying events or occurrences that may constitute abuse or neglect. The following are examples to be further investigated. 1. Further investigation will be conducted for any of the following: ...Injury to resident of undetermined origin; any marks, bruise, laceration, fracture that resident sustains that was not witnessed or specifically reported occurrence on incident report." It also revealed, "The Administrator or their designee will notify the state agency and local law enforcement of the suspicion of a crime, abuse or neglect. In the event of serious bodily injury, notify both the state and local police department within 2 hours. Self-reporting of suspected crime, abuse or neglect to state agencies and local law enforcement is mandatory. All other suspicion of crime, abuse and neglect notify the state agency and local police department within 24 hours after forming the suspicion."</p>	F 225			

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F 225	Continued From page 5 The facility failed to ensure an incident where a resident had an unwitnessed fall and sustained a fracture was immediately reported to the State survey and certification agency.	F 225			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278			

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F 278	<p>Continued From page 6</p> <p>The facility census totaled 52 residents with 7 residents included in the sample. Of those, all 7 residents were reviewed for the accuracy of their assessments. Based on observation, interview and record review, the facility failed to accurately assess the resident's fall history for 1 of 7 sampled residents. (#1)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #1's Significant Change MDS (Minimum Data Set) assessment dated 7/24/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 8 (moderate cognitive impairment). It revealed the resident needed extensive assistance of one person for transfers, walking in room and corridors, locomotion on and off the unit, and had one fall with injury (not major injury) since the prior assessment. <p>Review of the Quarterly MDS assessment dated 10/10/13 revealed the resident had a BIMS of 10 (moderate cognitive impairment), and needed extensive assistance of one person for transfers, walking in room and corridor, and locomotion on and off the unit. The assessment revealed the resident had no falls since the previous assessment.</p> <p>The Cognitive Loss CAA (Care Area Assessment) for the 7/24/13 Significant Change MDS revealed the resident demonstrated a change in mental status since the last assessment, and had demonstrated some difficulty with orientation in regards to time/date and some short term memory. The resident maintained conversation, answered questions appropriately, and understood others and could</p>	F 278			

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F 278	<p>Continued From page 7</p> <p>be understood. It also revealed, "Resident has had a change in ADL (activities of daily living) scores and requires more help since last assessment."</p> <p>The Fall CAA for the 7/24/13 Significant Change MDS revealed the resident had an actual fall with bruising. The resident had medication orders for diuretics as well as narcotic pain medication and an antidepressant. The resident has restricted range of motion to his/her shoulder, and was also a 1 person assist. The resident used a gait belt and walker for ambulation with assistance of 1 person, and his/her ADL score had declined as well as his/her BIMS since the last assessment.</p> <p>A note on 9/10/13 at 2:51 A.M. revealed the resident experienced a fall that shift. The resident slid off the edge of his/her bed, had no injuries noted, and no complaints of pain voiced. Staff re-educated the resident on the importance of using the call bell for all needs. The resident acknowledged understanding of the teaching, and staff were re-educated to check on the resident frequently.</p> <p>A note dated 9/23/2013 at 9:35 A.M. revealed, at 8:15 A.M. a nurse aide notified the writer that the resident was on the floor. The writer entered the room and found the resident on the floor just in the closet doorway lying on his/her left side with knees bent. The resident complained of pain at a 10 (1 to 10 scale, 10 being the worst) to the left hip, and range of motion could not be performed. The resident reported he/she reached for clothes in the bottom of the closet. The walker and wheelchair were several feet away and not within the resident's reach. The nurse aide last checked on resident at 7:15 A.M. The writer notified the</p>	F 278			

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F 278	Continued From page 8 APRN, and staff sent the resident to the emergency room for further assessment. Observation at 2:18 P.M. on 12/11/13 revealed the resident lay in bed. At that time, the resident reported he/she remembered falling and breaking his/her hip, but did not remember what he/she was doing just prior to the fall. During an interview at 3:33 P.M. on 12/16/13, Administrative Nursing staff K reported the resident's falls from 9/23/13 and 9/10/13 did not show up on the electronic fall tracking list so they did not get coded on the MDS. Staff K reported the MDS should have identified the two falls the resident experienced before that time. Review of the facility's undated MDS (Minimum Data Set) policy revealed it is the policy of the facility that each facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The facility failed to have a quarterly MDS assessment that accurately reflected the resident's fall history.	F 278			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279			

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F 279	<p>Continued From page 9</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 52 residents with 7 residents included in the sample. Of those, 7 residents were reviewed for comprehensive care plans. Based on observation, interview and record review, the facility failed to have a comprehensive care plan for 5 of 7 sampled residents regarding falls and ADLs (activities of daily living). (#1, #3, #4, #6, #7.)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #1's Significant Change MDS (Minimum Data Set) assessment dated 7/24/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 8 (moderate cognitive impairment). It revealed the resident needed extensive assistance of one for transfers, walking in room and corridors, locomotion on and off the unit, and had one fall with injury (not major injury) since the prior assessment. <p>Review of the Quarterly MDS assessment dated 10/10/13 revealed the resident had a BIMS of 10</p>	F 279			

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F 279	<p>Continued From page 10</p> <p>(moderate cognitive impairment), and needed extensive assistance of one person for transfers, walking in room and corridor, locomotion on and off the unit. The assessment revealed the resident had no falls since the previous assessment.</p> <p>The Cognitive Loss CAA (Care Area Assessment) for the 7/24/13 Significant Change MDS revealed the resident demonstrated a change in mental status since last assessment, and had demonstrated some difficulty with orientation in regards to time/date and some short term memory. The resident maintained conversation, answered questions appropriately, understood others and could be understood. It also revealed, "Resident has had a change in ADL (activities of daily living) scores and requires more help since last assessment."</p> <p>The Fall CAA for the 7/24/13 Significant Change MDS revealed the resident had an actual fall with bruising. The resident had medication orders for diuretics as well as narcotic pain medication and an antidepressant. The resident has restricted range of motion to his/her shoulder, and was also a 1 person assist. The resident used a gait belt and walker for ambulation with assistance of 1 person, and his/her ADL score had declined as well as his/her BIMS since the last assessment.</p> <p>Review of the care plan in place prior to a fall the resident experienced on 11/17/13 revealed the resident had an alteration in his/her musculoskeletal status related to pain in the right knee after an unwitnessed fall on 7/17/13. The care plan had interventions to assist the resident with the use of supportive devices (wheelchair, walker as recommended), follow physician orders</p>	F 279			

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F 279	<p>Continued From page 11</p> <p>for weight bearing status, and give analgesics as ordered and monitor and document for side effects and effectiveness. The care plan also revealed the resident had limited physical mobility related to weakness. The resident used a wheelchair and walker for locomotion, monitor for signs and symptoms of immobility, and provide therapy referrals as ordered and as needed. The care plan failed to include the resident's high risk for falls, history of multiple falls, or interventions staff needed follow to help reduce the risk for further falls.</p> <p>A note on 9/10/13 at 2:51 A.M. revealed the resident experienced a fall that shift. The resident slid off the edge of his/her bed, had no injuries noted, and no complaints of pain voiced. Staff reeducated the resident on the importance of using the call bell for all needs. The staff failed to develop a fall care plan for the resident.</p> <p>A note dated 9/23/13 at 9:35 A.M. revealed, at 8:15 A.M. a nurse aide notified the writer that the resident was on the floor. The writer entered the room and found the resident on the floor just in the closet doorway lying on his/her left side with knees bent.</p> <p>A nurse's note on 11/17/13 at 6:22 P.M. revealed the resident on the floor, lying on his/her left arm, and the left side of his/her face on the ground, head toward the entrance of the door and legs toward the recliner. The call light was pulled out from the wall, the walker sat next to the recliner, away from the resident. A blanket was found on the floor in between his/her leg. The resident stated he/she just got back from the bathroom, and fell when trying to get back to the recliner and lost balance.</p>	F 279			

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F 279	<p>Continued From page 12</p> <p>Observation at 2:18 P.M. on 12/11/13 revealed the resident lay in bed. At that time, the resident reported he/she remembered falling and breaking his/her hip, but did not remember what he/she was doing just prior to the fall. The resident reported he/she needed 2 staff to help him/her get around most of the time.</p> <p>During an interview at 2:55 P.M. on 12/11/13, Direct Care staff E and Direct Care staff F both reported, before the fall on 11/17/13, the resident ambulated in his/her room independently, including going to the bathroom and walking out to meals. Staff E reported the resident would call if he/she needed assistance, and staff F reported he/she did not think the resident had increased risk for falls because the resident walked well and was not unsteady.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the purpose of the care plan was to tell the staff how to care for the resident.</p> <p>Review of the facility's undated Comprehensive Care Plan policy revealed, "3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident."</p> <p>The facility failed to have a comprehensive fall care plan for a resident regarding his/her history of falls, high fall risk, and interventions to help reduce the risk for falls.</p> <p>- Review of resident #3's electronic Face Sheet revealed the resident admitted to the facility on 9/30/13.</p>	F 279			

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F 279	<p>Continued From page 13</p> <p>Review of the Admission Assessment dated 9/30/2013 revealed the resident at risk for falls.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment dated 10/13/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 6 (severe cognitive impairment). It revealed the resident needed limited assist of 2 people for bed mobility, limited assist of 1 person for transfers, walking and locomotion. The resident had a fall in last month prior to admission, and in last 2-6 months prior to admission, but had not experienced falls since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) for Admission MDS revealed the resident needed limited to extensive assistance from staff for transfers and ambulation, and had moderate risk for falls. The resident used a walker with ambulation, needed to be reminded to get up slowly, and stand for a little bit before walking.</p> <p>Review of the undated Admission Care plan revealed, "At risk (for falls) score." It also revealed the resident needed assist of 1-2 staff for transfers, ambulated with 2 person assist, and needed assistance of 1 for turning and repositioning. It revealed, "Toileting q2hrs (every 2 hours) and PRN (as needed)." It also revealed the resident oriented x 2 (person and place), disoriented, forgetful, and had dementia/Alzheimer's (progressive mental deterioration characterized by confusion and memory failure).</p> <p>Review of the comprehensive care plan (due 10/10/13) revealed it failed to identify the resident at risk for falls, have interventions to help prevent</p>	F 279			

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F 279	<p>Continued From page 14</p> <p>falls, and failed to include the assistance the resident needed with daily cares until the resident experienced a fall on 11/1/13 when it staff added the resident had an actual fall and unsteady gait and poor balance.</p> <p>During an interview at 12:40 P.M. on 12/12/13 Direct Care staff J, he/she reported the resident at risk for falls, and used a walker with a gait belt for ambulation and transfers. At 1:31 P.M. that same day, staff J reported staff needed to stay in the room if the resident needed extra time in the restroom because the resident would get up without calling for help. Staff J reported the resident too confused to know to call for help.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the care plan needed to include the resident's care needs, any issues and included the resident's input. Staff K reported the care plan told the staff how to care for the resident.</p> <p>Review of the facility's undated Comprehensive Care Plan policy revealed, "3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident."</p> <p>The facility failed to have a comprehensive care plan addressing his/her fall risk and ADL needs.</p> <p>- Review of resident #4's electronic record face sheet revealed the resident admitted to the facility on 9/14/13.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment dated 9/20/13 revealed the resident had a BIMS (Brief Interview Mental</p>	F 279			

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F 279	<p>Continued From page 15</p> <p>Status) score of 15 (cognitively intact), needed extensive assistance of 1 for bed mobility, transfers, locomotion off unit, needed limited assistance of 1 for walking, and locomotion on the unit. The resident had no falls in the 6 months prior to admission, and had 1 non-injury fall since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) for the 9/20/13 Admission MDS revealed the resident at risk for falls due to safety unawareness, weakness impaired mobility and pain. The resident had fallen here at the facility one time, without injury, and stated that he/she fell because he/she was trying to transfer from the chair to the bed. Currently, the resident had a call light within reach at all times, and staff provided education to use the call light. It also revealed the resident had impaired balance, and received medications which increased risk for falls.</p> <p>Review of the the Admission Care plan dated 9/21/13 (not initiated until 7 days after the resident admitted to the facility) revealed the resident at risk for falls. It revealed a toileting program of every 2 hours and at the resident's request, needed assistance of 1 person for transfers, used a walker and ambulated with assist of one person. It also revealed the resident alert, forgetful, resistive to care/noncompliant.</p> <p>Review of the resident's comprehensive care plan revealed, (initiated on 10/5/13) due to increased confusion, it directed staff to remind the resident each time in the resident's room for the resident to use the call light to call for assistance. The care plan did not include the resident's fall risk, fall prevention interventions, or ADL (activities of</p>	F 279			

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F 279	<p>Continued From page 16</p> <p>daily living) needs and abilities prior to the fall on 10/9/13.</p> <p>A note on 9/16/13 3:34 A.M. also revealed the resident walked unsteady to the bathroom, and the resident did not use the call light all the time. Staff re-educated the resident to use the call light when in need of help, the resident's bed was in low position and the call light within reach.</p> <p>Another note on 9/19/13 at 11:09 A.M. revealed, "Fall follow up- No injuries notes- No acute pain noted, chronic pain continues, Cont (continue) to remind res. (resident) to ask/wait for assistance."</p> <p>A note 9/19/13 at 8:50 P.M. revealed a nurse performed a head to toe assessment on the resident, assessed the resident's range of motion, and revealed the resident had no new injuries. Staff notified the director of nursing, the physician, and family, and re-educated the resident on the importance of using the call light system and not getting up without assistance.</p> <p>A nurses note on 9/21/2013 at 2:14 A.M. revealed the resident fell at 1:50 A.M. The resident said he/she was trying to go to the bathroom and lost balance. The resident denied pain at that time, but did receive a skin tear on the left elbow. Staff again re-educated the resident to use the call light when in need of help.</p> <p>A note on 10/9/13 at 9:49 P.M. revealed, at 9:15 P.M., someone found the resident on the floor. The resident was alert and oriented, and complained of pain in his/her left shoulder. The resident said it "just wasn't right." Staff contacted the physician, and the resident was sent from the building.</p>	F 279			

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F 279	<p>Continued From page 17</p> <p>During an interview with Direct Care staff J at 12:40 P.M. on 12/12/13, he/she reported he/she remembered the resident had a bed pad alarm at one point, and had a few falls tripping over the resident's oxygen cord. Staff J reported he/she had to make sure the oxygen tubing was not in the resident's way when staff helped the resident to the bathroom. Staff J reported he/she thought the resident had the most trouble with following directions and stability just after waking up in the morning, but after that, the resident acted fine the rest of the day. The resident needed assistance from one staff member, and used a gait belt and walker for locomotion.</p> <p>At 11:47 A.M. on 12/12/13, Licensed Nursing staff G reported the resident a very big fall risk. The resident had the physical ability to do things and the mental ability to do it, but staff G reported the resident had problems with his/her oxygen level when he/she stood up. Staff G reported he/she expected aides to check on the resident about every 2 hours due to his/her history of falls. When the resident first admitted to the facility, the resident would call and ask for assistance, but as time progressed, the resident needed more cueing and reminding to complete daily tasks.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the purpose of the care plan was to tell the staff how to care for the resident.</p> <p>Review of the facility's undated Comprehensive Care Plan policy revealed, "3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident."</p>	F 279			

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F 279	<p>Continued From page 18</p> <p>The facility failed to have a comprehensive care plan that reflected the resident's high fall risk, interventions directing staff how to reduce the risk for falls, or the resident's ADL abilities and needs.</p> <p>- Review of resident #7's Admission MDS assessment dated 11/26/13 revealed the resident had a BIMS of 15 (cognitively intact). The resident needed extensive assistance of 2 people for bed mobility, transfers, walking in his/her room, dressing, and toilet use. The resident needed limited assistance of one for walking in the corridor, locomotion on/off the unit, and personal hygiene. The resident needed supervision and setup help for eating, had no falls prior to admission or since admission.</p> <p>Review of the resident's temporary care plan revealed, alert and oriented x 3, needed incontinent care and to take to bathroom, assist of 1 for transfers, used a cane/quad (type of assistive walking device) and wheelchair for mobility, assist of one with grooming and bathing, assist of one for turning and repositioning, received routine and PRN (as needed) pain medications, and was diabetic with a controlled carbohydrate diet.</p> <p>Review of the resident's Comprehensive care plan initiated 11/28/13 revealed the resident planned to remain in the facility. Received PT (Physical Therapy) services (listed specific service), had an OT (Occupational Therapy) clarification order (with specific service), had a medical history of depression, and listed interventions. The resident also had a Medication Care plan, with listed medications and their warnings. The care plan lacked the resident's ADL (activities of daily living) assistance needs,</p>	F 279			

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F 279	<p>Continued From page 19</p> <p>diabetic and diet needs, activity wants and needs, and care the resident needed assistance with from staff.</p> <p>During an interview at 11:00 A.M. on 12/16/13, Direct Care staff L reported the resident needed extensive assistance with dressing, but had a remote controlled wheelchair and could get around independently. Staff L reported staff tallied the residents intake and output, and used a urinal for his/her output. Staff L reported he/she did not think the resident was a diabetic, and did not need assistance with eating or hygiene. Staff L reported he/she would look at the care plan book if he/she had questions about a resident's care.</p> <p>Observation at 11:04 A.M. on 12/16/13 revealed the resident reclined in a recliner chair, and watched television. The resident reported he/she planned to stay living in the facility, and reported he/she needed assistance with most of his/her daily cares.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the purpose of the care plan was to tell the staff how to care for the resident.</p> <p>At 4:49 P.M. on 12/16/13, Administrative Nursing staff B and Consultant C reviewed the resident's care plan and reported the care plan did not comprehensively address the resident's care needs.</p> <p>Review of the facility's undated Comprehensive Care Plan policy revealed, "3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident."</p>	F 279			

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F 279	<p>Continued From page 20</p> <p>The facility failed to have a comprehensive care plan for a resident regarding his/her ADL, fall risk, diabetic, dietary and activity needs.</p> <p>- Review of resident #6's electronic Face Sheet revealed the resident admitted to the facility on 9/12/13.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment dated 9/19/13 revealed the resident had no difficulty with short and long term memory, needed limited assistance of 1 staff member for bed mobility, extensive of 2 staff for transfers, walking in room and locomotion on unit, and limited assistance of 2 staff for walking in corridor, and locomotion off the unit did not occur. The resident experienced a fall in last month prior to admission, staff were unable to determine if the resident had a fall in the 2-6 months prior to admission or if the resident experienced a fracture in that time. No falls since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) for the admission MDS dated 9/19/13 revealed the resident admitted to the facility for long term care and was post pubic rami (a part of the pelvis) fracture. The resident had a fall about 2 weeks prior to admission per the history and physical. The resident had chronic knee pain with a history of a total knee replacement, and required extensive assistance of 1-2 staff members for many ADLs (activities of daily living). The resident took scheduled and "as needed" pain medication, and incontinent of urine at times.</p> <p>Review of the undated temporary care plan revealed the resident needed prompting every 2</p>	F 279			

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F 279	<p>Continued From page 21</p> <p>hour to toilet in the bathroom, assistance of 1 staff for transfers, used a walker and wheelchair, ambulated with assist of one and a gait belt, was at risk for falls, and needed assistance of 1 person for repositioning.</p> <p>Review of the resident's comprehensive care plan (to be completed at the latest, 21 days after admission) revealed the resident had an actual fall with no injury related to unsteady gait, poor balance, poor communication/comprehension (initiated on 11/14/13 and revised on 12/5/13). It revealed the resident needed a "safe environment with even floors free from spills and/or clutter ; adequate , glare free light, a working and reachable call light, the bed in low position at night; slide fails as ordered, handrails on the walls, personal items within reach (initiated on 12/5/13), Be sure call light is within reach and encourage to use it for assistance as needed. Needs prompt response to all requests for assistance (12/5/13). Check range of motion (specify) times daily (initiated 12/5/13). Continue interventions on the at-risk plan (initiated 12/5/13). For no apparent acute injury, determine and address causative factors of the fall (initiated 12/5/13)." The comprehensive care plan did not reflect the resident's fall history, fall risk or fall interventions in place to help reduce the risk for falls until after the resident had another fall on 11/14/13. The care plan also failed to include the resident's current ADL abilities or needs from staff.</p> <p>Review of a nurses note dated 9/15/13 at 10:54 P.M. revealed staff found the resident sitting on the floor. The resident said he/she was attempting to go to the bathroom by himself/herself and missed some steps. The</p>	F 279			

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F 279	<p>Continued From page 22</p> <p>resident could move all extremities without any difficulty or discomfort, and had no injuries. Staff instructed the resident to ask for help and not attempt to transfer himself/herself.</p> <p>Observation at 2:20 P.M. on 12/11/13 revealed the resident stood next to Direct Care staff F and held onto a walker. Direct Care M walked over, applied a gait belt to the resident and the two staff members held the gait belt and walked with the resident as they pulled the wheelchair behind. The staff members walked slowly and at the resident's pace as the resident ambulated around the perimeter of the house.</p> <p>During an interview at 3:20 P.M. on 12/11/13, the resident reported he/she remembered he/she had fallen, but did not remember what caused him/her to fall. The resident reported he/she could do some things on his/her own and some things he/she got help for.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the purpose of the care plan to tell the staff how to care for the resident.</p> <p>Review of the facility's undated Comprehensive Care Plan policy revealed, "3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident."</p> <p>The facility failed to have a comprehensive care plan for a resident regarding his/her fall risk, history of falls, interventions to reduce the resident's risk for falls, and ADLs needs and abilities.</p>	F 279			
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2013
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
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F 281 SS=D	<p>Continued From page 23</p> <p>PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 52 residents with 7 residents included in the sample. Of those, 5 residents were reviewed for admission care plans. Based on observation, interview and record review, the facility failed to have an accurate, timely care plan on admission for 2 of 7 sampled residents. (#4 and #6)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #4's electronic record face sheet revealed the resident admitted to the facility on 9/14/13. <p>Review of the the Admission Care plan dated 9/21/13 (not initiated until 7 days after the resident admitted to the facility) revealed the resident at risk for falls. It revealed a toileting program of every 2 hours and at the resident's request, needed assistance of 1 person for transfers, used a walker and ambulated with assist of one person. It also revealed the resident was alert, forgetful, resistive to care/noncompliant. The care plan did not have any fall interventions marked as in place at that time.</p> <p>Review of a nurses noted dated 9/15/13 at 1:32 P.M. revealed the resident needed supervised assistance of 1 staff member with all ADLs (activities of daily living) and transfers, and</p>	F 281			

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F 281	<p>Continued From page 24</p> <p>ambulated with a walker. The note revealed the resident very unsteady, and able to feed himself/herself. The resident had no admission care plan to direct staff on how to assist the resident in these areas.</p> <p>A note on 9/16/13 3:34 A.M. also revealed the resident walked unsteady to the bathroom, and the resident did not use the call light all the time. Staff re-educated the resident to use the call light when in need of help, the resident's bed was in low position and the call light within reach. The resident had no admission care plan to address the resident's need for re-education to use the call light for assistance from staff.</p> <p>Another note on 9/19/13 at 11:09 A.M. revealed, "Fall follow up- No injuries notes- No acute pain noted, chronic pain continues, Cont (continue) to remind res. (resident) to ask/wait for assistance." The resident had no admission care plan to address the resident's increased fall risk, or a fall the resident experienced in the facility.</p> <p>On 12/12/13 at 2:08 P.M., Consultant C reported an admission care plan needed to be created on the day of admission for each resident. Consultant C reported there had been a lot of changes in administration and that may have been why the care plan was late.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the care plan told the staff how to care for the resident.</p> <p>After requests, the facility did not provide a policy regarding admission care plans.</p> <p>The facility failed to have a care plan on</p>			F 281			

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F 281	<p>Continued From page 25 admission for resident #4.</p> <p>- Review of resident #6's electronic Face Sheet revealed the resident admitted to the facility on 9/12/13.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment dated 9/19/13 revealed the resident had good short and long term memory, needed limited assistance of 1 staff for bed mobility, extensive of 2 staff for transfers, walking in room and locomotion on unit, and limited assistance of 2 staff for walking in corridor, and locomotion off the unit did not occur. The resident experienced a fall in last month prior to admission, staff were unable to determine if the resident had a fall in the 2-6 months prior to admission or if the resident experienced a fracture in that time. No falls since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) for the admission MDS dated 9/19/13 revealed the resident admitted to the facility for long term care and was post pubic rami (a part of the pelvis) fracture. The resident had a fall about 2 weeks prior to admission per the history and physical. The resident had chronic knee pain with a history of a total knee replacement, and required extensive assistance of 1-2 staff members for many ADLs (activities of daily living). The resident took scheduled and "as needed" pain medication, and incontinent of urine at times.</p> <p>Review of the undated temporary care plan revealed the resident needed prompting every 2 hours to the bathroom for toileting, assistance of 1 staff for transfers, used a walker and wheelchair, ambulated with assist of one and a</p>	F 281			

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F 281	<p>Continued From page 26</p> <p>gait belt, had risk for falls, and needed assistance of 1 person for repositioning. The care plan did not reflect the fall the resident experienced on 9/15/13.</p> <p>Review of a nurses note dated 9/15/13 at 10:54 P.M. revealed staff found the resident sitting on the floor. The resident said he/she was attempting to go to the bathroom by himself/herself and missed some steps. The resident could move all extremities without any difficulty or discomfort, and had no injuries. Staff instructed the resident to ask for help and not attempt to transfer himself/herself. The record lacked any indication staff completed an investigation after the fall to ensure staff provided the care as planned, provided adequate supervision, or determine if the current interventions for fall prevention remained effective.</p> <p>Observation at 2:20 P.M. on 12/11/13 revealed the resident stood next to Direct Care staff F and held onto a walker. Direct Care M walked over, applied a gait belt to the resident and the two staff members held the gait belt and walked with the resident as they pulled the wheelchair behind. The staff members walked slowly and at the resident's pace as the resident ambulated around the perimeter of the house.</p> <p>During an interview at 3:20 P.M. on 12/11/13, the resident reported he/she remembered he/she had fallen, but did not remember what caused him/her to fall. The resident reported he/she could do some things on his/her own and some things he/she got help for.</p> <p>At 3:35 P.M. on 12/16/13, Administrative Nursing</p>	F 281			

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F 281	Continued From page 27 staff K reported the care plan told the staff how to care for the resident. After requests, the facility did not provide a policy regarding admission care plans. The facility failed to revise and update the resident's admission care plan when the resident experienced a fall 3 days after admission.	F 281			
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 52 residents with 7 residents included in the sample. Of those, 6 residents (including 3 closed records) were reviewed for accidents. Based on observation, interview and record review, the facility failed to ensure that each resident's environment remained as free from accident hazards as possible and each resident received adequate supervision and assistance devices to prevent falls by the failure to investigate each fall to attempt to determine the cause of the fall and failed to review the care plan and implement new/effective interventions to prevent further falls. The failure to investigate falls and implement effective interventions resulted in 4 residents	F 323			

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F 323	<p>Continued From page 28</p> <p>sustaining fractures after falling. (#1, #2, #3, #4, #5 and #6)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #1's signed physician's orders sheet dated 11/27/13 revealed the following diagnoses: difficulty in walking, general osteoarthritis involving multiple sites (condition of chronic arthritis without inflammation), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), other specified rehabilitation procedure, muscle weakness (generalized), and noninfectious lymphedema (swelling caused by accumulation of lymph). <p>The resident's significant change MDS (Minimum Data Set) assessment dated 7/24/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 8 (moderate cognitive impairment). It revealed the resident needed extensive assistance of one person for transfers, walking in room and corridors, locomotion on and off the unit, and had one fall with injury (not major injury) since the prior assessment.</p> <p>Review of the quarterly MDS assessment dated 10/10/13 revealed the resident had a BIMS of 10 (moderate cognitive impairment) and needed extensive assistance of one person for transfers, walking in room and corridor, and locomotion on and off the unit. The assessment revealed the resident had no falls since the previous assessment. The assessment failed to include 2 falls the resident experienced during the assessment time frame.</p> <p>The Cognitive Loss CAA (Care Area</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>Assessment) dated 7/24/13 revealed the resident demonstrated a change in mental status since the last assessment, and had demonstrated some difficulty with orientation in regards to time/date and some short term memory. The resident maintained conversation, answered questions appropriately, and understood others and could be understood. It also revealed the resident has had a change in ADL (activities of daily living) abilities and required more help since the last assessment.</p> <p>The Fall CAA dated 7/24/13 revealed the resident had an actual fall with bruising. The resident had restricted range of motion to his/her shoulder and was also a 1 person assist. The resident used a gait belt and walker for ambulation with assistance of 1 person and his/her ADL abilities had declined as well as his/her BIMS since the last assessment.</p> <p>Review of the resident's fall risk assessment dated 5/12/13 revealed the resident with a score of 17 indicating high risk for falls.</p> <p>Review of the care plan in place prior to a fall the resident experienced on 11/17/13 revealed the resident had an alteration in his/her musculoskeletal status related to pain in the right knee after an unwitnessed fall on 7/17/13 (initiated on 7/17/13). The care plan had interventions to assist the resident with the use of supportive devices (wheelchair, walker as recommended), follow physician orders for weight bearing status, and give analgesics as ordered and monitor and document for side effects and effectiveness. The care plan also revealed the resident had limited physical mobility related to weakness. The resident used a wheelchair and</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>walker for locomotion, and directed staff to monitor for signs and symptoms of immobility, and provide therapy referrals as ordered and as needed. The care plan did not include the resident's high risk for falls after the resident experienced the fall on 7/17/17, interventions staff needed follow to help reduce the risk for further falls, or updates after each fall the resident experienced.</p> <p>A nurses note on 7/17/13 at 9:37 A.M. revealed staff found the resident on the toilet in his/her room crying, stating, "I couldn't make it and I wet and fell on the floor." Staff took the resident's vitals and identified a fresh bruise to the resident's knee, tender to the touch, and the resident winced/whimpered when he/she attempted to straighten his/her leg. Staff finished the assessment, assisted the resident from the bathroom and notified the physician and family. The record lacked evidence staff reassessed the resident's status and reviewed or updated the plan of care to ensure it remained effective.</p> <p>Nurses' note on 9/10/13 at 2:51 A.M. revealed the resident experienced a fall that shift. The resident slid off the edge of his/her bed, had no injuries noted, and no complaints of pain voiced. Staff re-educated the resident on the importance of using the call bell for all needs. The resident acknowledged understanding of the teaching, and staff were re-educated to check on the resident frequently. The record lacked evidence staff reassessed the resident's status and reviewed or updated the plan of care to ensure it remained effective.</p> <p>A nurses' note dated 9/23/2013 at 9:35 A.M. revealed, at 8:15 A.M. a nurse aide notified the</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>writer that the resident was on the floor. The writer entered the room and found the resident on the floor just in the closet doorway lying on his/her left side with knees bent. The resident complained of pain at a 10 (1 to 10 scale, 10 being the worst) to the left hip, and range of motion could not be performed. The resident reported he/she reached for clothes in the bottom of the closet. The walker and wheelchair were several feet away and not within the resident's reach. The nurse aide last checked on resident at 7:15 A.M. The writer notified the APRN, and staff sent the resident to the emergency room for further assessment. Further review of the record revealed the resident returned to the facility without injury. Staff failed to reassess the resident's status and failed to review and update the care plan after the resident returned from the hospital to ensure the interventions were effective.</p> <p>Review of a note dated 11/10/13 at 12:13 A.M. revealed the resident required extensive assistance with toileting, ADLs and locomotion with his/her wheelchair.</p> <p>A nurse's note on 11/17/13 at 6:22 P.M. revealed the resident on the floor, lying on his/her left arm, and the left side of his/her face on the ground, head toward the entrance of the door and legs toward the recliner. The call light was pulled out from the wall, the walker sat next to the recliner, away from the resident. A blanket was found on the floor in between his/her leg. The resident stated he/she just got back from the bathroom, and fell when trying to get back to the recliner and lost balance. "My legs and hip hurt!" "My back and left shoulder hurt!" The nurses note revealed the resident had 2 carpet burns on left elbow and</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>left cheek, and was alert and oriented to person, place and time, but was slightly confused. The resident described the pain location to the hips, left leg, upper back and left shoulder blade. Nursing staff called emergency medical services (EMS) along with all other needed contacts, placed a pillow under the resident's head and stayed with him/her until the ambulance arrived. EMS left the building with the resident around 5:00 P.M. to head toward the hospital. The results of the hospital visit revealed the resident had a left hip fracture.</p> <p>Observation at 2:18 P.M. on 12/11/13 revealed the resident lay in bed covered with a blanket and his/her call light within reach. At that time, the resident reported he/she remembered falling and breaking his/her hip, but did not remember what he/she was doing just prior to the fall. The resident reported he/she needed 2 staff to help him/her get around most of the time. On 12/12/13 at 11:43 A.M., the resident reported he/she did not remember being visited the day prior.</p> <p>During an interview at 2:55 P.M. on 12/11/13, Direct Care staff E and Direct Care staff F both reported, before the fall on 11/17/13, the resident ambulated in his/her room independently, including going to the bathroom and walking out to meals. Staff E reported the resident would call if he/she needed assistance, and staff F reported he/she did not think the resident had increased risk for falls because the resident walked well and was not unsteady.</p> <p>During an interview at 11:47 A.M. on 12/12/13, Licensed Nursing staff G reported the resident did have a risk for falls prior to the fall on</p>	F 323			

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F 323	<p>Continued From page 33</p> <p>11/17/13. Staff G reported the resident used a walker, and needed supervised assistance every time the resident was up, walked, went to the bathroom or to the dining room. Up until the fall on 11/17/13, the resident had a bed side and night table with items he/she liked to have close by. Staff G reported the resident utilized those items, and staff needed to make sure those things were within reach.</p> <p>During an interview at 6:00 P.M. on 12/12/13, Administrative nursing staff C reported the facility did not have any investigations from the multiple falls prior to the fall the resident experienced on 11/17/13. Staff C reported the falls should have been investigated and the care plan updated with appropriate interventions to help prevent future falls.</p> <p>During an interview at 10:00 A.M. on 12/16/13, Physician H reported the resident did have a fall where the resident experienced hip pain, was sent to the emergency room and came back with no major injuries. The resident again fell on 11/17/13 and did sustain a hip fracture. Physician H reported he/she expected staff to investigate falls to know what things could be done differently to help prevent further falls. Physician H reported staff could not prevent every fall, but did need to follow the care plan.</p> <p>The facility failed to investigate after each fall to help determine any needed changes to the resident's care to help prevent additional falls. The resident experienced a fall with a fracture to his/her left hip.</p> <p>- Review of resident #2's (a closed record) signed physician's orders sheet dated 7/3/13</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>included the following diagnoses: other specified rehabilitation procedure and atrial fibrillation (rapid, irregular heart beat).</p> <p>Review of the admission/5 day MDS (Minimum Data Set) assessment dated 5/30/13 revealed the resident had short and long term memory impairment, needed extensive assistance of 2 people for transfers, walking and toilet use, and needed extensive assistance of 1 person for bed mobility, and locomotion. It also revealed the resident did have a fall in the month prior to admission, but had not experienced a fall since admission.</p> <p>Review of the Cognitive Loss/Dementia CAA (Care Area Assessment) for the 5/30/13 MDS revealed the resident had a medical history of CVA (cerebrovascular accident (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain)) and ischemic stroke in 2011 which caused the resident to have short term, long term, and recall memory deficits, and was alert to person only. The resident had disorientation to time, place and date, and currently received medication for dementia. The CAA revealed, since the resident's recent hospitalization, the resident's delirium had become worse as he/she had begun having seizures and a steady health decline. Also since the hospitalization, the resident had increased neurological deficits which decreased the resident's continence ability, and required frequent reorientation due to a medical history of dementia and memory loss.</p> <p>Review of the Fall CAA for the 5/30/13 MDS revealed the resident had a potential for falls.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
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F 323	<p>Continued From page 35</p> <p>He/she had a history of falling prior to admission and had a new onset of seizures. The resident got anxious and attempted to get up unattended. The resident had alarms for prevention, and required extensive assistance for transfers and ambulation.</p> <p>Review of the resident's admission care plan dated 5/24/13 revealed the resident at risk for falls. The resident had a low bed, bed and/or chair alarm, oriented to self, alert, and had dementia/Alzheimer's. The plan directed staff to use simple short commands, the resident needed incontinent care for bowel and bladder, had a toileting schedule every 2 hours, and the resident needed assistance of 1 for transfers, repositioning and ambulation. The resident used a wheelchair for mobility.</p> <p>A comprehensive care plan also initiated on 5/24/13, and revised on 11/12/13 revealed the resident was at risk for falls and had an actual fall during the resident's stay. The resident had a fall risk related to confusion, poor comprehension, hearing problems, and gait/balance problems. Interventions initiated on 5/24/13 revealed direction to staff to assist with all transfers and ambulation, bed alarm to the bed and must be set each time the resident was placed in bed, have the resident sit in the dining area and give an activity when awake, involve the resident in an activity to redirect attempts to get up unattended, therapy to evaluate and treat as ordered, use a gait belt each time transferred, and do not leave the gait belt on once seated. On 6/6/13 additions to the care plan included the resident frequently requested to use the bathroom, had a restorative toileting program, and while awake it directed staff to assist the resident to the bathroom every</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>2 hours, when the resident was in bed, set the bed to the lowest position, and when restless, provide a group or individual activity to divert attention from trying to stand unattended.</p> <p>The record also included a Care Plan Addendum dated 6/19/13 which revealed the resident was at high risk for falls due to recent falls. An update on 6/27/13 included, "bed in lowest position and chair and bed alarm requested. Frequent monitoring."</p> <p>Review of a nurses note dated 6/3/13 at 2:35 P.M. revealed staff found the resident in another resident's room on the floor in front of his/her wheelchair. "[He/She] was trying to get up to go to the bathroom." It identified staff had assisted the resident to the bathroom every hour and the resident had confusion at times. Staff assessed the resident and found no injury, and would continue to assess for changes in condition. The record lacked evidence staff reassessed the resident's status and reviewed or updated the plan of care to ensure it remained effective.</p> <p>A nurses' note dated 6/18/13 at 8:44 A.M. revealed the resident repeatedly asked to use the restroom and staff redirected, and the resident received antibiotic therapy for a urinary tract infection. The resident did not follow commands completely but was able to follow small direct instructions, especially during transfers and toileting. "A high fall risk and measures in place include chair and bed alarm. Nursing continue to re-educate and reemphasize safety cues."</p> <p>A nurses' note dated 6/20/13 at 1:27 A.M. revealed the resident was "very agitated" that night and wanted to be out in the common area in</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>the resident's wheelchair. The resident sat in the area adjacent to the nurses station when the resident tried to stand up from the wheelchair and fell to the floor before the staff could get to him/her. The resident received an abrasion to his/her forehead. The record lacked evidence as to whether staff attempted to determine why the resident was agitated, reassessed the resident or updated the resident's plan of care.</p> <p>Another nurses' note dated 6/28/13 at 6:00 P.M. revealed fall interventions included continuous visual supervision, bed alarm and fall mat to floor continued. The note made no mention of the chair alarm.</p> <p>Review of a note dated 6/28/13 at 7:04 A.M. revealed the resident "has been restless all evening." The resident continued to get up and down out of his/her wheelchair without assistance. The resident had increased strength through working with therapy ambulating with his/her walker. At 11:10 P.M. (on 6/27/13), the resident was found laying on the floor in front of his/her wheelchair in front of his/her bed. The note also revealed, "Bed in low position, walker requested to management, bed and chair alarm requested to management." The record lacked evidence staff reassessed the resident's status and reviewed or updated the plan of care to ensure it remained effective.</p> <p>A nurses' note on 6/29/13 at 10:27 A.M. revealed, "Observed right wrist/forearm bruised and swollen. Painful with flexion or extension."</p> <p>A note from the Advanced Practice Registered Nurse dated 7/1/13 revealed, "The patient continues on skilled services. [Gender] does have</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>dementia with behaviors. [Gender] is currently on Coumadin therapy. [Gender] did undergo a fall last week with increased pain over the weekend. X-ray was obtained. It did show that [gender] had a minimally impacted cortical fracture at the dorsum of the distal radius."</p> <p>During an interview with Direct Care staff I on 12/12/13 at 4:36 P.M., he/she reported the resident had confusion, hollered out at times and was not reliable to use the call light. Staff I reported, if he/she told the resident something one day, the resident would not remember it the next day. Staff also reported the resident was impulsive, and did get up without assistance. At times when the resident acted restless, staff I took the resident to the living area and provided a snack which helped. Having the family visit helped and he/she also remembered the resident had a bed and chair alarm before the fall. Staff I reported he/she checked on the resident every 2 hours, but when the resident became restless, the resident needed to be in the sight of staff at all times.</p> <p>During an interview at 4:10 P.M. on 12/12/13, Consultant C reported he/she could not find any investigations for the 3 falls the resident experienced to show where staff were at the times of the falls, if the interventions in place had been effective, or if new interventions needed to be in place, and reported investigations should have been completed to obtain that information. Consultant C reported, by looking at the nurses note for the fall on 6/27/13, he/she could not tell what the resident was attempting to do. Consultant C reported the previous notes did identify an alarm was in place and the note for the fall on 6/27/13 revealed staff requested one.</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>Consultant C reported he/she did not know what happened to the alarm. Consultant C reviewed the nurse aide documentation and reported the aides last assisted the resident and documented at 9:23 P.M. prior to the fall. Consultant C reported he/she expected staff to check on residents more frequently if doing so every 2 hours was not effective in keeping the resident safe. Consultant C also reported, based on the fall history and the resident's impulsive behavior, the resident should not have been left alone in the resident's room if the resident was restless. Consultant C reported he/she expected staff to follow the admission care plan when the resident first came into the facility. After completing the Admission CAAs, staff had 10 days to put a comprehensive care plan in place. Consultant C reported he/she the comprehensive care plan in effect by 6/10/13.</p> <p>During an interview with Physician H at 10:00 A.M. on 12/16/13, he/she reported the resident had dementia and did need a lot of attention. Physician H reported he/she expected staff to investigate falls to know what things could be done differently to help prevent further falls. Physician H reported staff could not prevent every fall, but did need to follow the care plan.</p> <p>The facility failed to thoroughly investigate falls to ensure staff provided the resident's care needs as planned, provided adequate supervision, and ensure the current fall interventions remained effective.</p> <p>- Review of resident #3's (a closed record) signed physician's orders sheet dated 11/4/13 revealed diagnoses including the following: type 2 diabetes (when the body can't use glucose,</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>there's not enough insulin made or the body can't respond to the insulin), congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid), renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), depressive disorder, and inflammatory disease of the prostate.</p> <p>The electronic record face sheet revealed the resident admitted to the facility on 9/30/13.</p> <p>Review of the Admission nursing assessment dated 9/30/2013 revealed the resident at risk for falls.</p> <p>Review of the resident's admission/5 day MDS (Minimum Data Set) assessment dated 10/13/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 6 (severe cognitive impairment). It revealed the resident needed limited assistance of 2 people for bed mobility, limited assistance of 1 person for transfers, walking and locomotion. The resident had a fall in last month prior to admission, and in last 2-6 months prior to admission, but had not experienced falls since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) dated 10/13/13 revealed the resident needed limited to extensive assistance from staff for transfers and ambulation, and had a moderate risk for falls. The resident used a walker with ambulation, needed to be reminded to get up slowly and stand for a little bit before walking.</p> <p>Review of the undated Admission care plan revealed the resident had a fall risk score identifying the resident at risk for falls. It also</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>revealed the resident needed assistance of 1-2 people for transfers, ambulated with 2 person assist, and needed assistance of 1 for turning and repositioning. "Toileting q2hrs (every 2 hours) and PRN (as needed)." The resident was oriented x 2 (person and place), disoriented, forgetful and had dementia/Alzheimer's.</p> <p>Review of the comprehensive care plan dated 11/1/13 indicated the resident had an actual fall and unsteady gait and poor balance.</p> <p>Review of a nurses note dated 10/15/13 at 4:11 P.M. revealed the resident was alert and confused at times with memory loss.</p> <p>Another note on 10/26/13 at 10:06 A.M. revealed the resident alert, and confused at times with memory loss.</p> <p>A nurses note on 11/1/13 at 11:47 A.M. revealed the "resident in the bathroom, and fell outside of bathroom." The resident stated he/she was trying to walk without a walker. The record lacked evidence staff provided care and supervision as planned, reassessed the resident's status and reviewed and/or updated the plan of care to ensure it remained effective.</p> <p>Review of a nurses note dated 11/2/2013 at 2:09 A.M. revealed the resident continued on fall follow-up and complained of pain in the right lower rib area. Staff notified the physician and received an order for a rib X-ray.</p> <p>Review of a Preliminary Report from Radiology Services Corporation dated 11/2/13 revealed a reason for the X-ray: pain after fall 11/1/13. Findings: Fracture 9th rib. No underlying pleural or parenchymal traumatic/post traumatic</p>	F 323			

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F 323	<p>Continued From page 42 changes.</p> <p>On 12/11/13 at 12:32 P.M., Administrative staff A reported he/she did not know the location of the investigation for the fall the resident experienced on 11/1/13.</p> <p>During an interview at 12:40 P.M. on 12/12/13 with Direct Care staff J, he/she reported the resident was at risk for falls and used a walker with a gait belt for ambulation and transfers. At 1:31 P.M. on 12/12/13, staff J reported staff needed to stay in the room if the resident needed extra time in the restroom because the resident would get up without calling for help. Staff J reported the resident was too confused to know to call for help.</p> <p>Review of the Aide Documentation Report for November 2013 revealed, "Toileting Program (restorative): Take to bathroom every 2 hours during waking hours" to be documented on each day that month. The report revealed staff charted at 11:42 and 11:43 A.M. on 11/1/13 that they took the resident to the bathroom. During an interview at 1:45 P.M. on 12/12/13, Consultant C reported the charting program and cueing information for staff was not initially set up for individual resident needs. When a resident admitted to the facility, questions/cues like taking to the bathroom every 2 hours were automatically turned on for all residents. Staff C reported the direction did not specify whether staff needed to stay with the resident, or not to leave the resident unattended.</p> <p>During an interview at 2:08 P.M. on 12/12/13, Administrative nursing staff B reported he/she did not have any evidence to show an investigation had been completed to determine whether staff</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>assisted the resident as the resident needed, and had nothing to show that staff did not leave the resident unattended on the toilet.</p> <p>During an interview at 12:30 P.M. on 12/18/13 Physician O had no additional information regarding the resident's fall.</p> <p>The facility failed to investigate a fall to ensure staff provided care as planned and interventions remained appropriate.</p> <p>- Review of resident #4's signed admission orders dated 9/16/13 revealed diagnoses including the following: rehabilitation procedure, malignant (a medical condition, especially with tumors, to become progressively worse. This is most familiar as a characteristic of cancer) neoplasm (tumor) bronchus and lung, shortness of breath, chronic pain, hypertrophy (enlargement) prostate without urinary obstruction, and anemia.</p> <p>The electronic record face sheet revealed the resident admitted to the facility on 9/14/13.</p> <p>Review of the admission/5 day MDS (Minimum Data Set) assessment dated 9/20/13 revealed the resident had a BIMS (Brief Interview Mental Status) score of 15 (cognitively intact), needed extensive assistance of 1 person for bed mobility, transfers, locomotion off unit, needed limited assistance of 1 person for walking, and locomotion on the unit. The resident had no falls in the 6 months prior to admission, and had 1 non-injury fall since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) for the 9/20/13 Admission MDS revealed the</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>resident was at risk for falls due to safety unawareness, weakness impaired mobility and pain. The resident had fallen at the facility one time without injury, and stated that he/she fell because he/she was trying to transfer from the chair to the bed. The resident had a call light within reach at all times, and staff provided education to use the call light. It also revealed the resident had impaired balance, and received medications which increased the risk for falls.</p> <p>Review of the the Admission Care plan dated 9/21/13 (staff failed to initiate until 7 days after the resident admitted to the facility) revealed the resident at risk for falls. It revealed a toileting program every 2 hours and at the resident's request, the resident needed assistance of 1 person for transfers, used a walker and ambulated with assist of one person. It also revealed the resident was alert, forgetful, and resistive to care/noncompliant. The care plan did not have any fall interventions marked as in place at that time.</p> <p>Review of the resident's comprehensive care plan revealed (initiated on 10/5/13) due to increased confusion, staff needed to remind the resident each time in the resident's room to use the call light to call for assistance. The care plan did not include the resident's fall risk, ADL (activities of daily living) needs, or updates to the care plan after the resident experienced falls prior to the fall on 10/9/13.</p> <p>Review of a nurses noted dated 9/15/13 at 1:32 P.M. revealed the resident needed assistance of 1 staff member with all ADLs, transfers and ambulated with a walker. The note revealed the resident was very unsteady and able to feed</p>	F 323			

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F 323	<p>Continued From page 45 himself/herself.</p> <p>A nurses' note on 9/16/13 at 3:34 A.M. also revealed the resident walked unsteady to the bathroom, and the resident did not use the call light all the time. Staff re-educated the resident to use the call light when in need of help, the resident's bed was in low position and the call light within reach.</p> <p>A nurses' note on 9/19/13 at 11:09 A.M. revealed, "Fall follow up- No injuries notes- No acute pain noted, chronic pain continues, Cont (continue) to remind res. (resident) to ask/wait for assistance." The resident's medical record lacked any description of the fall or assessment of the resident immediately following the fall. The record lacked any description of the the fall that occurred, whether staff reassessed the resident's current needs, or any review or updates to the care plan to ensure the interventions remained effective.</p> <p>A note on 9/19/13 at 8:50 P.M. revealed a nurse performed a head to toe assessment on the resident, assessed the resident's range of motion, and revealed the resident had no new injuries. Staff notified the director of nursing, the physician, and family, and re-educated the resident on the importance of using the call light system and not getting up without assistance. The record did not include the reason for the re-education or notifying parties related to the resident's status, or follow-up as to whether the education had been effective.</p> <p>A nurses note on 9/21/2013 at 2:14 A.M. revealed the resident fell at 1:50 A.M. The resident said he/she was trying to go to the bathroom and lost</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>balance. The resident denied pain at that time, but did receive a skin tear on the left elbow. Staff again re-educated the resident to use the call light when in need of help. The record lacked evidence where staff reassessed the resident, or reviewed/updated the care plan to ensure it remained effective.</p> <p>Review of the Documentation Survey Report (a report of the documentation direct staff input into an electronic charting system) revealed staff documented at 9:59 P.M. after providing care on 9/20/13, and did not document again until 2:43 A.M. on 9/21/13. The documentation report revealed no staff asked or assisted the resident to toilet within or at 2 hours prior to the fall.</p> <p>A nurses' note on 10/9/13 at 12:10 A.M. revealed the resident was alert and oriented to person, place and time, but was unable to verbalize wants and needs that evening as the resident was having confusion with hallucinations. The resident required assistance of 1 person for ADLs, the resident had his/her bed in the low position and call light within reach.</p> <p>A nurses' note on 10/9/13 at 9:49 P.M. revealed, at 9:15 P.M., someone found the resident on the floor. The resident was alert and oriented, and complained of pain in his/her left shoulder. The resident said it "just wasn't right." Staff contacted the physician, and the resident was sent from the building to the hospital. The investigation completed after the fall included written statements from staff who worked that shift. The statements lacked information on when staff last saw the resident, and the resident's physical and behavioral state at that time. The investigation failed to determine whether staff assisted the resident in a timely manner with care as planned,</p>	F 323			

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F 323	<p>Continued From page 47</p> <p>and whether the call light was on when staff found the resident. The investigation had "clutter" marked as a predisposing factor, but did not describe or include further investigation into what the clutter was or if it affected the situation.</p> <p>During an interview with Direct Care staff J at 12:40 P.M. on 12/12/13, he/she reported he/she remembered the resident had a bed pad alarm at one point, and the resident had a few falls tripping over the resident's oxygen cord. Staff J reported he/she had to make sure the oxygen tubing was not in the resident's way when staff helped the resident to the bathroom. Staff J reported he/she thought the resident had the most trouble with following directions and stability just after waking up in the morning, but after that, the resident acted fine the rest of the day. The resident needed assistance from one staff member, and used a gait belt and walker for locomotion.</p> <p>At 11:47 A.M. on 12/12/13, Licensed Nursing staff G reported the resident was a very big fall risk. The resident had the physical and mental ability to do things, but staff G reported the resident had problems with his/her oxygen level when he/she stood up. The resident's oxygen saturation level would lower, and the resident would fall. Staff G reported he/she expected aides to check on the resident about every 2 hours due to his/her history of falls. When the resident first admitted to the facility, the resident would call and ask for assistance, but as time progressed, the resident needed more cueing and reminding to complete daily tasks.</p> <p>At 5:02 P.M. on 12/16/13, Administrative Nursing staff B and Consultant C both reported the resident at risk for falls on admission and staff</p>	F 323			

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F 323	<p>Continued From page 48</p> <p>needed to check on the resident every 2 hours. If the resident's risk or needs increased, both staff B and Consultant C reported they expected staff to increase the frequency of checking on the resident.</p> <p>During an interview at 10:00 A.M. on 12/16/13 Physician H reported the resident admitted to the facility for reconditioning, and strengthening to be able to go home. Physician H reported the resident did sustain a fracture to the arm from the fall, but was not a surgical candidate. Physician H reported he/she expected staff to investigate falls to know what things could be done differently to help prevent further falls. Physician H reported staff could not prevent every fall, but did need to follow the care plan.</p> <p>The facility failed to thoroughly investigate after each fall to determine if the current interventions remained effective, provide supervision/assistance as planned to prevent the resident from ambulating to the bathroom independently, and failed to review and update the care plan after each fall the resident experienced to ensure the interventions remained effective.</p> <p>- Review of resident #6's physician's orders sheet signed by the physician and dated 11/27/13 revealed diagnoses including the following: other specified aftercare following surgery, hip joint replacement by other means, and general osteoarthritis (condition of chronic arthritis without inflammation) involving multiple sites.</p> <p>Review of the electronic Face Sheet revealed the resident admitted to the facility on 9/12/13.</p>	F 323			

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F 323	<p>Continued From page 49</p> <p>Review of the admission/5 day MDS (Minimum Data Set) assessment dated 9/19/13 revealed the resident had okay short and long term memory, needed limited assistance of 1 for bed mobility, extensive of 2 for transfers, walking in room and locomotion on unit, and limited assistance of 2 for walking in corridor, and locomotion off the unit did not occur. The resident experienced a fall in the last month prior to admission, staff were unable to determine if the resident had a fall in the 2-6 months prior to admission or if the resident experienced a fracture in that time. The resident experienced no falls since admission.</p> <p>Review of the Fall CAA (Care Area Assessment) dated 9/19/13 revealed the resident admitted to the facility for long term care and was post pubic rami fracture. The resident had a fall "about 2 weeks" prior to admission per the history and physical. The resident had chronic knee pain with a history of a total knee replacement, and required extensive assistance of 1-2 staff members for many ADLs (activities of daily living). The resident took scheduled and "as needed" pain medication and was incontinent of urine at times.</p> <p>Review of the undated temporary care plan revealed the resident needed prompting every 2 hours for bathroom toileting, assistance of 1 staff for transfers, used a walker and wheelchair, ambulated with assist of one and a gait belt, had risk for falls, and needed assistance of 1 person for repositioning. The care plan did not reflect the fall the resident experienced on 9/15/13.</p> <p>Review of the resident's comprehensive care plan revealed the resident had an actual fall with no injury related to unsteady gait, poor balance, poor</p>			F 323			

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F 323	<p>Continued From page 50</p> <p>communication/comprehension (the initiated problem on 11/14/13 and revised on 12/5/13). It revealed the resident needed a safe environment with clutter free, and clean floors, a working and reachable call light, the bed in low position at night; slide fails as ordered, handrails on the walls, personal items within reach (initiated on 12/5/13), be sure the call light is within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance (12/5/13). The care plan directed staff to check range of motion daily (initiated 12/5/13), continue interventions on the at-risk plan (initiated 12/5/13). For no apparent acute injury, it directed staff to determine and address causative factors of the fall (initiated 12/5/13). The comprehensive care plan did not include the resident's current ADL abilities or needs from staff.</p> <p>Review of a nurses note dated 9/15/13 at 10:54 P.M. revealed staff found the resident sitting on the floor. The resident said he/she was attempting to go to the bathroom by himself/herself and missed some steps. The resident could move all extremities without any difficulty or discomfort, and had no injuries. Staff instructed the resident to ask for help and not attempt to transfer himself/herself. The record lacked evidence the facility reassessed the resident and reviewed/updated the care plan to ensure the interventions remained effective.</p> <p>Review of the Documentation Survey Report (a report of the documentation direct staff input into an electronic charting system) for 9/15/13 revealed no indication staff had assisted the resident to the restroom within 2 hours prior to the fall on 9/15/13.</p>	F 323			

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F 323	<p>Continued From page 51</p> <p>Review of a nurses note dated 11/14/13 at 4:32 P.M. revealed the writer was notified by staff that the resident was on the floor. The resident was found sitting on floor in between the wheelchair and recliner, with his/her back facing the door. The resident was alert and oriented, able to move all extremities. Staff assisted the resident back into the recliner. "Before leaving room, water pitcher was refilled, personal items, and call light within reach. Educate pt (patient) about the importance of using call light when in need." The record lacked evidence staff reassessed the resident's needs and reviewed or updated the care planned to ensure the interventions remained effective.</p> <p>Observation at 2:20 P.M. on 12/11/13 revealed the resident stood next to Direct Care staff F and held onto a walker. Direct Care M walked over, applied a gait belt to the resident and the two staff members held the gait belt and walked with the resident as they pulled the wheelchair behind. The staff members walked slowly and at the resident's pace as the resident ambulated around the perimeter of the house.</p> <p>During an interview at 3:20 P.M. on 12/11/13, the resident reported he/she remembered he/she had fallen, but did not remember what caused him/her to fall. The resident reported he/she could do some things on his/her own and some things he/she got help for. At that time, observation revealed the resident sat in his/her recliner with his/her call light and grabber within reach.</p> <p>During an interview at 2:50 P.M. on 12/11/13, Direct Care staff F and Direct care staff M reported the resident tried to do things by</p>	F 323			

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F 323	<p>Continued From page 52</p> <p>himself/herself but was unsteady, and needed rest breaks. Staff M reported the resident might try to go to the bathroom by himself/herself and did not always call for help so staff needed to check on the resident frequently. Staff F and Staff M reported they needed to check on residents every 2 hours, but Staff F and Staff M continually did rounds if not charting or assisting a resident because they like to "keep an eye on" everyone.</p> <p>During an interview at 7:55 A.M. on 12/16/13, Administrative staff A reported staff could not find fall investigations completed for the falls on 9/15/13 and 11/14/13.</p> <p>The facility failed to provide supervision as planned for the resident, and investigate each fall to determine the cause and whether the current interventions remained effective to prevent further falls.</p> <p>- Review of resident #5's physician's orders sheet signed 11/27/13 revealed it included the following diagnoses: other specified rehabilitation procedure, orthopedic aftercare, and generalized muscle weakness.</p> <p>Review of the Admission MDS (Minimum Data Set) assessment dated 6/20/13 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 14 (cognitively intact). The resident needed extensive assistance of 1 for bed mobility and locomotion off unit, extensive assistance of 2 for transfers, walking in room/corridor and locomotion on the unit. The resident had no fall in last month prior to admission, had a fall in the last 2-6 months with fracture related to a fall in last 6 months prior to admission. The assessment also revealed the</p>	F 323			

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F 323	<p>Continued From page 53</p> <p>resident had one fall with no injury since admission and one fall with major injury.</p> <p>Review of the Quarterly MDS assessment dated 12/1/13 revealed the resident with a BIMS of 15 (cognitively intact). The resident needed extensive assistance of 2 staff for bed mobility/transfers, walking in his/her room and locomotion off the unit, walking in the corridor occurred only 1 or 2 times, and needed extensive assistance of one person for locomotion on the unit. The resident had 2 or more falls with injury (except major) since the prior assessment.</p> <p>Review of the Fall CAA (Care Area Assessment) for 6/20/13 Admission MDS revealed the resident at high risk for falls. The resident had weakness and unsteadiness from a recent hospitalization, had a right hip replacement, and had cognitive impairment since the surgery. The resident now had poor safety awareness, attempted to stand up unassisted and required assistance with transfers. The resident also had restlessness related to pain, received scheduled pain medication and therapy.</p> <p>Review of the resident's current care plan revealed the resident had high risk for falls, had an actual fall on 7/11/13 during his/her stay, had weakness and unsteadiness from a recent hospitalization. The resident had a right hip replacement, had cognitive impairment since his/her surgery, and now has poor safety awareness. The resident attempted to stand up unassisted, and required assist with transfers. The resident had restlessness related to pain (added to the care plan on 6/18/13 and revised 9/19/13). It directed staff to add a non-skid surface to wheelchair (initiated 7/11/13, revised</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>8/6/13). On 6/24/13, staff added dycem (non-slip material) under the inflatable ring to prevent sliding, changed to a more comfortable bed and provide medication to help relieve coccyx pain and attempts to get out of bed, and provide Miralax (a medication) for constipation due to increased anxiety where the resident kept attempting to stand due to discomfort. Staff frequently reminded the resident to not stand without assist, and the resident received therapy. It directed staff to serve the resident after most other residents to prevent the resident from leaving the table after meals (initiated 7/20/13 and revised 7/22/13), and toilet after eating (initiated 7/22/13). When anxious, it also directed staff to place the resident in the dining area, provide diversional activity cards, dominoes, puzzles, and have a bed alarm to the bed once obtained (initiated on 6/18/13 and revised on 7/22/13). On 11/25/13, staff added providing a pendant call light, with return demonstration of the pendant use demonstrated initiated, completed a urinalysis with culture and sensitivity on 12/2/13, receive oxygen at 2 liters to maintain an oxygen saturation at 92% or with complaints of shortness of air (initiated 12/1/13). It also revealed, when not in bed, encourage the resident to sit in the dining area or community television area, and provide with activity as available (initiated 7/20/13 and revised 11/25/13).</p> <p>Review of the Self Care deficit care plan (initiated 6/24/13) revealed the resident had recently had a hospitalization for a right hip replacement, required extensive assistance with transfers and ambulation, used the wheelchair for his/her primary mode of locomotion, but had unsteadiness and weakness. The care plan revealed the resident required extensive assist</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>with transfers and toileting, ambulated with a walker, and could propel himself/herself short distances.</p> <p>Review of a nurses note on 9/17/13 at 10:23 A.M. revealed the resident was trying to help himself/herself to the bathroom without assistance from nursing staff and fell. The resident had a large elevated bruise superior to the left eye. The record lacked evidence staff reassessed the resident's status and reviewed or updated the plan of care to ensure it remained effective.</p> <p>A note on 9/24/13 at 3:40 P.M. revealed a nurse aide entered the resident's room to find the resident on his/her knees facing his/her bed. The record again lacked evidence staff reassessed the resident's status and reviewed or updated the plan of care to ensure it remained effective.</p> <p>A note dated 10/16/13 at 8:28 P.M. revealed, at approximately 2:00 P.M., staff heard someone calling for help from an area around a resident room. In the resident's room, staff found the resident lying on his/her back. The resident reported his/her chair slid out from under him/her and it happened so fast that he/she could not stop from falling. Assessment revealed the resident received 2 skin tears to the right forearm. The record failed to include any investigation as to when staff last assisted the resident, if staff had followed the resident's plan of care, or if the current interventions remained effective to help prevent further falls.</p> <p>On 11/1/13 at 3:49 P.M. a nurses note revealed the resident stated he/she was trying to get into his/her chair and fell over. The resident had</p>	F 323			

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F 323	<p>Continued From page 56</p> <p>orientation to person and place. The record lacked any indication staff investigated the fall to determine if staff had followed the care plan, provided adequate supervision, or if the current interventions remained effective to help prevent further falls.</p> <p>A nurses note dated 11/22/13 8:12 P.M. revealed the resident was found on the floor next to his/her bed by an medication aide. The resident stated he/she was trying to go to the rest room. The resident denied pressing the call light and attempted to ambulate unsupervised. The resident needed assistance of one staff member. The note revealed the resident denied pain, but complained of soreness to his/her right side because he/she fell on the trash can. The record lacked any investigation to show staff assisted or cued the resident to go to the bathroom in a timely manner, whether staff followed the resident's plan of care, or if the current interventions remained effective to help prevent further falls.</p> <p>Observation on 12/12/13 at 8:15 A.M. revealed the resident sat in a wheelchair at the dining room table and ate the morning meal. The resident started to slide down in his/her wheelchair. The resident asked a staff member for assistance to sit up more. Two staff members locked the wheelchair brakes, placed a gait belt around the resident and assisted the resident to sit back in his/her wheelchair, cueing the resident to help as they assisted him/her.</p> <p>During an interview at 11:20 A.M. on 12/16/13 Licensed Nursing staff N reported the resident needed one on ones at times, and staff tried to notice when the resident traveled from point the</p>	F 323			

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F 323	<p>Continued From page 57</p> <p>dining room area back to his/her room. Staff N reported he/she had staff check on the resident every 30 minutes or so at night. Staff N reported the resident liked to spend time in his/her room, and had confusion at times. Staff just needed to make sure they checked on him/her frequently.</p> <p>During an interview with Administrative staff A at 7:55 A.M. on 12/16/13, he/she reported staff could not find any investigations for the falls on 9/17, 9/24, 10/16, 11/1, and 11/22 at that time.</p> <p>The facility failed to investigate multiple falls the resident experienced to help determine the causes, and potentially determine effective interventions to prevent further falls.</p>	F 323			